PROCEDURAL GUIDANCE FOR IMPLEMENTATION OF POPULAR OPINION LEADER (POL)

CBO PROGRAM ANNOUNCEMENT RFP 04064
DEPARTMENT OF HEALTH AND HUMAN SERVICES

DESCRIPTION OF POPULAR OPINION LEADER

Popular Opinion Leader (POL), consists of a group of trusted, well-liked people who are recruited and trained to conduct a specialized type of outreach. This outreach includes endorsement of safer sexual behaviors in casual, one-on-one conversations with peers in their own social network at a range of venues and settings.[1] This intervention has been packaged by CDC's Diffusion of Effective Behavioral Interventions (DEBI) project and information on obtaining the intervention training and materials is available at www.effectiveinterventions.org.

POL was initially demonstrated to increase condom use in men who have sex with men and the intervention techniques can be adapted to a range of risk populations in a broad range of venues. In addition, this specialized form of outreach can be used to diffuse messages on a range of health behaviors through a community. For example, messages about HIV antibody testing, status disclosure, linkage to prevention and medical services may be diffused through this intervention.

During peer-to-peer conversations, the trained popular opinion leader corrects misperceptions, discusses the importance of HIV prevention, describes strategies he/she uses to reduce risk (e.g., keeping condoms nearby, avoiding sex when intoxicated, resisting coercion for unsafe sex), and recommends that the peer adopt safer sex behaviors, seek antibody testing, consider status disclosure to sexual partners, and/or seeks medical care if they are HIV positive. Popular opinion leaders may wear buttons, caps, jacket logos, t-shirts, key chains, or temporary tattoos displaying the project logo. The logo may also be used on posters around the community venues, as a conversation-starting technique. Each leader agrees to have at least 14 conversations and to recruit another popular opinion leader. It is important to recruit and train 15-20% of the persons in each social network in the target population into the POL program so that risk reduction and other health behaviors become normative and are diffused throughout the target population. Agency facilitators do the preparatory work and teach vital communications skills but it is through the efforts of community members that the community changes the way it thinks about protecting itself from HIV.

CORE ELEMENTS, KEY CHARACTERISTICS, AND PROCEDURES

Core Elements are those components that are critical features of an intervention's intent and design and that are thought to be responsible for its effectiveness and that consequently

must be maintained without alteration to ensure program effectiveness. Core elements are derived from the behavioral theory upon which the intervention is based. They are essential to the implementation of the program and cannot be ignored, added to, or changed. The 3 core elements of POL include:

1) Identification and enlistment of popular and well-liked opinion leaders to take on risk-reduction advocacy roles.

2) Training for cadres of opinion leaders to disseminate risk-reduction endorsement messages and prevention service utilization within their own social networks.

3) Support and reinforcement of successive waves of opinion leaders to help reshape social norms to encourage safer sex, antibody testing, disclosure HIV status to sexual partners, and finding and accessing medical care if HIV positive.

Key Characteristics are crucial activities and delivery methods for conducting an intervention, which may be tailored for different agencies and at-risk populations. These characteristics, however, can be adapted or tailored to meet the needs of the target population and ensure cultural appropriateness of the strategy. POL has the following key characteristics**:**

- Elicit the involvement, support, and cooperation of key "gatekeepers" in the community
- Identify and characterize the various social networks within the target population
- Using key informants, identify enough popular opinion leaders to equal at least 15% of each identified social network in the population. This percentage has been documented as the point at which social norms begin to shift.
- Provide training to opinion leaders on the following skills and knowledge:
    - Theory and philosophy of the intervention
    - Accurate information on HIV risk reduction
    - Practical advice on how to implement HIV risk reduction behavior changes
    - Communication skills for imparting HIV risk reduction information to others, including modeling and role-playing
    - Initiation of effective peer risk reduction conversations
- Seek the agreement of each opinion leader to have a specified number of conversations (e.g., 14) with at-risk friends and acquaintances within a specified period
- Place posters in the intervention venue and give opinion leaders buttons to wear when in the venue
- Recruit additional opinion leaders by asking each current opinion leader to bring friends to participate in the next wave of the intervention
- Train a new wave of opinion leaders to maintain program momentum
- Organize "reunion" meetings with all opinion leaders (first and successive waves) and key community gatekeepers to discuss maintenance of POL

Procedures describe the activities that make up the content of the intervention and provide direction to agencies or organizations regarding the conduct of the intervention. Procedures for POL follow:

Opinion leaders are identified and recruited from all of the major social networks in the target population. After recruitment, they attend four training sessions during which they discuss HIV/AIDS facts and myths, receive practical advice for changing behaviors, and learn and practice ways of reinforcing safer sex norms through risk reduction conversations with their friends and acquaintances. At these training sessions opinion leaders are taught how to endorse antibody testing and the desirability of knowing one's antibody status and describe their experiences in obtaining an HIV antibody test. They are also trained to encourage participation in partner counseling and referral services and status disclosure with future sexual partners and to endorse taking steps to access medical care if one is HIV positive.

For a CBO to maintain the intervention over time, each opinion leader in the first group is asked to invite two or more friends to attend the next training cycle. This second wave of opinion leaders begins the training as the first group finishes. When the second group completes the training, it recruits the third wave of opinion leaders. In this way, each group of opinion leaders invites the next and the intervention continues to diffuse health norms. As the number of trained opinion leaders increases, the number of conversations in the community that endorse safer sex, antibody testing, status disclosure, and seeking medical care if HIV positive also increases.

Before implementing POL, CBOs should elicit the involvement, support and cooperation of key community gatekeepers (i.e., leaders in the community) who help identify the popular opinion leaders and offer support for the intervention and its goals. The CBO staff implementing POL should then identify and characterize the various social networks within the population at risk. CBO staff then recruits opinion leaders by emphasizing their potential positive role as a popular resource to others in their community.

During POL training sessions, provide opinion leaders with:

- accurate information about HIV risk reduction,
- antibody testing technologies including rapid testing,
- the importance of partner counseling and referral services as a prevention strategy,
- the importance of status disclosure to sex partners, and
- the importance of seeking medical care if a person finds they are HIV positive.

Also during POL training sessions, provide opinion leaders with practical advice on how to implement HIV risk reduction behavior changes or how to seek antibody testing. An important aspect of POL training sessions is building the communication skills of the opinion leaders so that they can effectively communicate HIV risk reduction information to others in spontaneously initiated conversations. This is done by modeling the conversations during training and then providing opportunities for participants to role play and receive feedback on their conversations. Practicing safer sex, obtaining an HIV antibody test, disclosing HIV status, and seeking medical care if HIV positive are not topics that typically arise in casual conversations, so POL training must facilitate group problem-solving centered around how each opinion leader will initiate peer

conversations, allowing each person ample time to discuss issues particularly relevant to him or her. At the end of the POL training sessions, seek the agreement of each opinion leader to have a specified number of conversations with at-risk friends and acquaintances. CBO staff can recruit additional opinion leaders by asking each current opinion leader to bring friends to participate in the next wave of intervention trainings.

RESOURCE REQUIREMENTS

Because POL is an intervention that relies heavily on volunteers, an agency's staffing requirements are limited. Staff activities revolve around:

- identifying venues where the target population congregates,
- identifying the social networks within the population and each network's opinion leaders,
- recruiting and training successive waves of opinion leaders,
- providing materials that display the conversation-starting logo,
- hosting reunion parties for opinion leaders and gatekeepers, and
- maintaining quality assurance.

The annual staffing requirements include 200 hours of senior staff time, 202 hours of junior staff time, and 19 hours of administrative assistant time. These figures do not include time spent by gatekeepers who assist in identifying opinion leaders or the time spent by the opinion leaders to attend trainings, conduct risk reduction conversations, and recruit additional opinion leaders.

RECRUITMENT

The original target population for POL was gay men in mid-size cities but the intervention can be adapted to reach a broad range of populations and groups at risk.

Agencies wishing to implement POL should review the Procedural Guidance for Recruitment in this document to choose a recruitment strategy that will work in the setting in which they plan to implement POL.

PHYSICAL SETTING CHARACTERISTICS

The intervention needs a place to hold POL trainings and staff meetings. Ideally the place should have comfortable seating for having discussions and viewing videos. Staff meetings can be held in the CBO's office space. POL trainings should be held at the same place for each session, but the choice of location can vary. Some programs have held training sessions at an intervention venue during the hour before the venue opened for business. Agencies implementing POL should choose a training location that is easily accessible from public transportation routes. The opinion leaders' risk reduction conversations take place in community venues where the target population lives, works, and socializes.

NECESSARY POLICIES AND STANDARDS

Before an agency attempts to implement POL the following policies and procedures should be in place to protect clients, the agency, and the opinion leaders:

Targeting of Services: Agencies must establish criteria for, and justify the selection of, the target populations. Selection of target populations must be based on epidemiological data, behavioral and clinical surveillance, and the state or local HIV prevention plan created with input from the state or local community planning group(s).

Safety: Agency policies must exist for maintaining safety of workers and clients. Plans for dealing with medical or psychological emergencies must be documented.

Confidentiality: A system must be in place to ensure that confidentiality is maintained for all participants in the program. Before sharing any information with another agency to which a client is referred, signed informed consent from a client or his/her legal guardian must be obtained.

Linkage of Services: Recruitment and health education and risk reduction must be linked to counseling, testing, and referral services for clients of unknown status, and to care and prevention services for people living with HIV (PLWH). Agencies must develop ways to assess whether and how frequently the referrals made by staff were completed.

Data Security: Collect and report data consistent with CDC requirements to ensure data security and client confidentiality.

Cultural Competence: Agencies must strive to offer culturally competent service by being aware of the demographic, cultural, and epidemiological profile of their communities. Agencies should hire, promote, and train staff across all disciplines to be representative of and sensitive to these cultures. In addition, materials and services must be offered in the preferred language of clients/consumers where possible, or translation should be available if appropriate. Agencies should facilitate community and client/consumer involvement in designing and implementing prevention services to ensure that important cultural issues are incorporated. The Office of Minority Health of the Department of Health and Human Services has published the *National Standards for Culturally and Linguistically Appropriate Services in Health Care,* which should be used as a guide for ensuring cultural competency in programs and services. Please see the Cultural Competence section in the introduction of this document (page 9) for standards for developing culturally and linguistically competent programs and services.

Personnel Policies: Agencies conducting recruitment, outreach, and health education and risk reduction, must established a code of conduct. This code should include, but not be limited to, no drug or alcohol use, appropriate behavior with clients, and no loaning or borrowing of money.

Volunteers: If the agency is using volunteers to assist in or conduct this intervention, then the agency should know and disclose how their liability insurance and worker's compensation applies to volunteers. Agencies must ensure that volunteers also receive the same training and are held to the same performance standards as employees. Agencies must also ensure that volunteers sign and adhere to a confidentiality statement. All training should be documented.

QUALITY ASSURANCE

The following quality assurance activities should be in place when implementing POL:

1) **Implementation plan** to ensure that POL's core elements and key characteristics are all included and followed.

2) **Hands-on guidance** to improve opinion leaders' skill and comfort in initiating and conducting risk reduction endorsement conversations with friends and acquaintances within their own social networks.

3) **Training of staff and skills development** to ensure that staff thoroughly understand the intervention and its underlying theory, know correct risk-reduction information, identify social networks and their opinion leaders, have group facilitation skills, recruit and train successive waves of opinion leaders, and maintain and evaluate the intervention.

4) **Fidelity to Core Elements** to ensure program effectiveness. Agencies must not alter, ignore, add to, or change POL's core elements.

5) **Quality Assurance Fidelity Checklist** to track whether all of POL's key characteristics were followed.

6) **Customer Satisfaction Survey** conducted at regular intervals of the agency's choosing to measure the target population's exposure to and acceptance of the intervention and any changes they have made to their behaviors.

7) **Feedback Loops** to improve delivery of the intervention to the target population. Information on the impact of the intervention should be shared with opinion leaders whenever possible to encourage their continued involvement.

MONITORING AND EVALUATION

Evaluation and monitoring intervention activities include:

- Collecting and reporting standardized process and outcome monitoring data consistent with CDC requirements
- Entering and transmitting data for CDC-funded services on PEMS (Program Evaluation Monitoring System), a CDC-provided browser-based system, or describe plans to make a local system compatible with CDC's requirements

- Collecting and reporting data consistent with the CDC requirements to ensure data quality and security and client confidentiality
- Collaborating with CDC in assessing the impact of HIV prevention activities by participating in special projects, upon request.

KEY ARTICLES AND RESOURCES

[1]Kelly JA, St. Lawrence JS, Diaz YE, Stevenson, LY, Hauth AC, Brasfield TL, Kalichman SC, Smith JE, Andre ME. (1991). HIV risk behavior reduction following intervention with key opinion leaders of population: An experimental analysis. American Journal of Public Health, 81(2), 168-171.

Kelly JA, St. Lawrence JS, Stevenson Y, Hauth AC, Kalichman SC, Diaz YE, Brasfield TL, Koob JJ, Morgan MG. (1992). Community AIDS/HIV risk reduction: The effects of endorsement by popular people in three cities. American Journal of Public Health, 82 (11), 1483-1489.

Kelly JA, Murphy DA, Sikkema KJ, McAuliffe TL, Roffman RA, Solomon LJ, Winett RA, Kalichman SC, and the Community HIV Prevention Research Collaborative. (1997). Randomized controlled community-level HIV-prevention intervention for sexual risk behavior among homosexual men in US cities. The Lancet, 350, 1500-1505.

Miller RL, Klotz D, Eckholdt HM. HIV prevention with male prostitutes and patrons of hustler bars: Replication of an HIV prevention intervention. American Journal of Community Psychology, 26(1), 97-131.

Implementation materials and training and technical assistance for POL are available through the Dissemination Effective Behavioral Interventions program and can be accessed on the Internet at www.effectiveinterventions.org.

For more information on intervention, training and technical assistance, or to get your name on a list for a future training, please go to the website: www.effectiveinterventions.org

PROCEDURAL GUIDANCE FOR IMPLEMENTATION OF THE MPOWERMENT PROJECT

CBO PROGRAM ANNOUNCEMENT RFP 04064
DEPARTMENT OF HEALTH AND HUMAN SERVICES

DESCRIPTION OF THE MPOWERMENT PROJECT

The Mpowerment Project[1] is a community-level HIV prevention program that is run by a "Core Group" of 12 - 20 young gay/bisexual men from the community and paid intervention staff (coordinators). The young gay/bisexual men from the Core Group, along with other volunteers, design and carry out all project activities. Ideally, the project has its own physical space where most outreach events and meetings are held and which serves as a drop-in center where young men can meet and socialize during specified hours. The program relies on a set of four integrated activities:

- *Formal Outreach:* Teams of young gay/bisexual men go to locations frequented by young gay men to discuss and promote safer sex, deliver educational/informational literature on HIV risk reduction, and distribute condoms. Additionally, the team creates its own informational events to educate young gay men (e.g., discussion groups) at which safer sex can be promoted.
- *M-groups:* These peer-led, one-time, 3 hour meetings of 8-10 young gay/bisexual men discuss factors contributing to unsafe sex among the men (e.g., misconceptions about safer sex, poor sexual communication skills). Through skills-building exercises, the men practice safer sex negotiation role-play and correct condom use. Participants receive free condoms and lubricant and are trained and motivated to conduct informal outreach.
- *Informal Outreach:* Informal outreach consists of young men discussing safer sex as well as the importance of knowing one's serostatus and being tested for HIV with their friends in a relaxed, informal manner that promotes community norms. Informal outreach can also target other community norms such as the desirability to know one's HIV antibody status and take an HIV antibody test, or to disclose HIV status to potential sex partners, or to seek medical care if one is HIV positive.
- *Ongoing Publicity Campaign:* The campaign attracts men to the project by word of mouth and through articles and advertisements in gay, alternative or university newspapers.

The Mpowerment Project has been shown to reduce rates of unprotected anal intercourse among young gay/bisexual men in communities in which it has been implemented.[1,2]

The Mpowerment Project training manuals and video tapes are available by contacting mpowerment@psg.ucsf.edu or on the Internet at mpowerment.org. The program developers at the University of California San Francisco's Center for AIDS Prevention Studies offer low-cost, experiential trainings 3-4 times each year for project coordinators and program supervisors. Additionally, eligible organizations may also obtain free, on-going technical assistance from the CAPS team. TA providers are former Mpowerment Project coordinators who have extensive hands-on experience with the program and are trained to deliver personalized assistance.

CORE ELEMENTS, KEY CHARACTERISTICS, AND PROCEDURES

Core Elements are those components that are critical features of an intervention's or strategy's intent and design and that are thought to be responsible for its effectiveness. Consequently, they must be maintained without alteration to ensure program effectiveness. Core elements are derived from the behavioral theory upon which the intervention or strategy is based. They are essential to the implementation of the program and cannot be ignored, added to, or changed. There are eight core elements and one optional element for the Mpowerment Project:

1) Maintain a Core Group of 12-20 young gay men to design and carry out project activities.
2) Recruit volunteers to assist in the delivery of services and to make important decisions about the program
3) Use project coordinators to oversee project activities
4) Establish a project space where many of the project activities can be held
5) Conduct formal outreach including educational activities and social events
6) Conduct informal outreach to influence behavior change
7) Convene peer-led, one-time discussion groups (M-groups)
8) Conduct a publicity campaign about the project within the community

Optional Element

1) Convene a community advisory board

Key Characteristics are crucial activities and delivery methods for conducting an intervention, which may be tailored for different agencies and at-risk populations to meet the needs of the target population and ensure cultural appropriateness of the strategy. Key Characteristics of the Mpowerment Project are:

Core group:

- Makes important decisions
- Bases decisions on the project's guiding principles
- Membership has racial/ethnic/socioeconomic diversity
- Membership may change over time as new men join and men who have been in Core Group leave
- Supports and encourages each other and other friends about safer sex
- Meetings are fun, social, productive, and scheduled regularly
- Engages in reflective analysis of all parts of the project, its own role in the project, and issues facing young gay/bisexual men.

Volunteers:

- Represent diverse racial/ethnic/socioeconomic backgrounds
- Make important decisions
- Learn new skills and conduct meaningful/interesting work
- Support and encourage each other and other friends about safer sex
- Encounter a warm, appreciative, social, and welcoming atmosphere

Coordinators:

- Understand HIV prevention and community building
- Are knowledgeable about the local young gay/bisexual men's community
- Demonstrate leadership skills
- Oversee all Project activities
- Promote diverse racial/ethnic/socioeconomic involvement
- Support the Core Group and volunteers to develop and implement activities
- Begin the safer sex diffusion process
- Engage in reflective analysis of all parts of the project, their own role in the project, and issues facing young gay/bisexual men

Project space:

- Is safe and comfortable
- Is in an accessible, and appealing location.
- Displays safer sex posters and literature are displayed.
- Makes condoms and lubricants available.
- Makes referral information available
- Rapid testing may be offered in this space if privacy and confidentiality is ensured.

Formal Outreach:

- Promotes safer sex, HIV antibody testing, HIV status disclosure
- Sponsors appealing events and engaging performances
- Helps build community
- Provides social opportunities
- Creates opportunities for positive peer influence
- Recruits for M-groups and other project activities
- Empowers project volunteers
- Are scheduled regularly

Informal Outreach:

- Diffuses a norm of safer sex and testing for HIV
- Uses peer influence to change behavior
- Is achieved through non-judgmental and supportive peer interactions
- Is reinforced through other project activities

M-groups

- Facilitated by well-trained and skilled project staff and/or volunteers

- Address young gay/bisexual men's important issues
- Create social opportunities
- Teach safer sex education
- Teach and motivate informal outreach
- Teach sexual negotiation skills
- Encourage project involvement and volunteerism
- Are scheduled regularly

Publicity campaign

- Creates attractive informative materials
- Reminds young gay/bisexual men of the importance of safer sex, encourages HIV testing, and seeking medical care if HIV positive.
- Reaches all young gay/bisexual men in the community
- Targets young gay/bisexual men, not the general community.

Community Advisory Board (optional element)

- Includes 5 – 10 individuals, who are typically older than 30, who are knowledgeable about target population, public health in state and community, prior HIV prevention efforts, or other community institutions that reach target population
- Serves as a resource to Core Group
- Does not have day-to-day decision-making power

Procedures describe the activities that make up the content of the intervention and provide direction to agencies or organizations regarding the implementation of the intervention. Procedures for the Mpowerment Project follow.

Agencies begin the process of delivering the Mpowerment Project by first locating coordinators for the project by writing letters to agencies, and placing ads in local gay/bisexual, alternative, and university newspapers. Project coordinators are then hired and trained to be responsible for organizing all aspects of the intervention, including managing volunteers and all activities. They also influence the diffusion process of safer sex messages including messages about the importance of HIV testing. They facilitate the empowerment of the young men who join the project as Core Group members or volunteers.

Next, the agency conducts a community assessment which helps to identify:

- The different groups of young gay/bisexual men throughout the community (including what social spaces exist and where the different groups hang out)
- Resources (e.g., spaces in which to hold outreach events, especially those that attract young gay/bisexual men)
- People in the community who are relevant to the project (e.g., potential Community Advisory Board members, organizations that might support the project, places where you can advertise to or recruit young gay/bisexual men)

After the community assessment, agency representatives must contact community leaders and inform them of the project.

The Mpowerment Project is run by a volunteer Core Group of 12 to 20 young gay/bisexual men from the community. To assemble the Core Group, project leaders must first identify potential Core Group members from the different segments of the young gay/bisexual men's community, and second, describe the program to them and invite them to join the Core Group. The Core group meets weekly and with the assistance of additional volunteers can make key project decisions. These include naming the local project, planning intervention activities and developing materials. In cooperation with the coordinator, they also choose the project space and furnish it.

Volunteers from the young gay/bisexual men's community carry out most activities. They usually do not devote as much time as the Core Group members but their input into and help with activities is essential. Volunteers support each other and stress the importance of consistent safer sex and of HIV testing. Depending on funding levels, a stand-alone project housed by a CBO is the most typical structure. However a consortium of community agencies could sponsor the intervention.

The Core Group is also assisted by a Community Advisory Board which meets monthly to offer advice on intervention activities to the Core Group and the Project Coordinators. They also link the project to a range of community agencies.

Formal outreach includes outreach teams and outreach events. Outreach teams of young men go to venues to promote safer sex. They may drop in on a specific venue for very brief activities that attract attention and promote safer sex. A major aspect of formal outreach is the creation of events that will attract young gay/bisexual men and where safer sex can be promoted. The intervention sponsors a range of large and small outreach events designed to appeal to each segment of the young gay/bisexual men's community. These activities can include weekly video presentations, social gatherings, discussion groups, and community forums. he outreach events are designed to attract young gay/bisexual men to the project so that they can receive appropriate safer sex promotion and referral to HIV counseling, testing, and referral services. Safer sex and HIV testing messages are always infused into every project activity in an appealing and fun way. The outreach team uses entertaining approaches to educate young men about safer sex and encourage them to learn their HIV status, and adopt and maintain safer behaviors over time. The intervention also develops materials for distribution at events. These include safer sex information with motivational messages, condoms, water-based lubricants and invitations to intervention activities. Young men who attend the events can be invited to join the Core Group and participate in M-groups which may be led by a coordinator or by other peers if additional group leaders are needed. Young men desiring to join the Core Group or volunteer are encouraged to attend an M-group as an entry to the project, in order to learn about the project's goals and activities. The project should strive to recruit 15-20% of the estimated number of young gay/bisexual men in the community to attend an M-group so that safer sex norms can be conveyed through the community's social networks and bring about community-wide change.

Informal outreach consists of young gay/bisexual men communicating with friends in causal conversations about the need to engage in safer sex, know their HIV antibody status, disclose to potential sexual partners, and seek medical care if HIV positive. The goal is to develop a process of communication that promotes safer sex across the entire community. Young men learn how to

conduct informal outreach while attending the M-groups. They are asked to make a commitment to speak with several of their friends, give them safer sex packages, and invite them to an M-group.

An ongoing publicity campaign communicates project goals, health messages, and activities. Publicity campaigns use articles and advertisements in the alternative press, including gay and university newspapers; posters and fliers; internet web pages, chat rooms, e-mail distribution lists; and word of mouth publicity within social networks. The publicity campaign's goals are to establish awareness of the intervention; invite young men to become involved; and provide a continual reminder of safer sex norms.

RESOURCE REQUIREMENTS

Coordinators are responsible for organizing all aspects of the intervention, including recruiting Core Group members and volunteers and managing all personnel and activities. The original researchers recommend hiring at least 1.5 FTE coordinators should to manage the program. The needs of the program and community characteristics will dictate the number of coordinators that are needed. An administrative employee (e.g., HIV prevention manager) of the CBO typically supervises the Project Coordinator(s).

The intervention is designed by a Core Group of volunteers which should include young gay/bisexual men who are representative of the diversity of the population of young gay/bisexual men in the community. The volunteers also facilitate M-groups and plan all events related to the intervention.

Besides staff salaries, the major expense related to the delivery of the Mpowerment Project is the need for a dedicated space for the intervention which must be furnished and decorated, and should contain a VCR and television for use in groups. This space serves as a headquarters for the project, and as a community center for young gay and bisexual men. The project space is where the project holds most of its outreach events and staff meetings. During certain hours it also serves as a drop-in center where young men can socialize, get information about community organizations and services, obtain referrals, and obtain safer sex materials. HIV testing may be offered if privacy and confidentiality can be assured.

RECRUITMENT

The target population for the Mpowerment Project is young gay and bisexual men (ages 18-29). Recruitment for the M-groups, the core group, the community advisory board is accomplished through both formal and informal outreach, and through use of an ongoing publicity campaign. Agencies choosing to implement the Mpowerment Project, should also review the Procedural Guidance for Recruitment in this document to choose a recruitment strategy that will work in the setting in which they plan to implement the Mpowerment Project.

PHYSICAL SETTING CHARACTERISTICS

The target population for the Mpowerment Project is young gay and bisexual men (ages 18-29). Recruitment for the M-groups, volunteers the Core Group and to the informational activitiesis accomplished through both formal and informal outreach, and through use of an ongoing publicity campaign. Agencies choosing to implement the Mpowerment Project should also review the Procedural Guidance for Recruitment in order to choose a recruitment strategy that will work in the setting in which they plan to implement the Mpowerment Project. Additional training and technical assistance about recruitment for the Mpowerment Project are available from the original research team at the Center for AIDS Prevention Studies.

NECESSARY POLICIES AND STANDARDS

Before an agency attempts to implement the Mpowerment Project the following policies and procedures should be in place to protect participants, the agency, and the Mpowerment Project intervention team:

Informed Consent: Agencies must have a consent form which carefully and clearly explains in accessible language the agency's responsibility and the participants' rights. Individual state laws apply to consent procedures for minors, but at a minimum consent should be obtained from each participant and, if appropriate, a legal guardian if the participant is a minor or unable to give legal consent. Client participation either as a volunteer, a Core Group member, or an M-group member must always be voluntary and documentation of this informed consent must be maintained in the client's record.

Legal/Ethical Policies: It is important to keep in mind that the Mpowerment Project is an intervention that may deal with disclosure of HIV status. Agencies must know their state laws regarding disclosure of HIV status to sexual and/or needle-sharing partners, and agencies are obligated to inform participants of the potential duty warn and the agency's responsibility. Agencies also must inform participants about state laws regarding the reporting of domestic violence, child abuse, sexual abuse of minors, and elder abuse.

Confidentiality: A system must be in place to assure that the confidentiality of those who choose to participate in the program is maintained.

Data security: All process and outcome data collected from or associated with participants (including worksheets, progress reports, attendance records, etc.) must be kept in a locked, secure location with only designated program staff able to access it.

Cultural Competence: Agencies must strive to offer culturally competent service by being aware of the demographic, cultural, and epidemiological profile of their communities. Agencies should hire, promote, and train staff across all disciplines to be representative of and sensitive to these cultures. In addition, materials and services must be offered in the preferred language of clients/consumers where possible, or translation should be available if appropriate. Finally, agencies should facilitate community and client/consumer involvement in designing and

implementing prevention services to ensure that important cultural issues are incorporated. The Office of Minority Health of the Department of Health and Human Services has published the *National Standards for Culturally and Linguistically Appropriate Services in Health Care* which should be used as a guide for ensuring cultural competency in programs and services.

Referrals: Agencies must be prepared to supply appropriate referrals to session participants as necessary. Providers must know about referral sources for prevention interventions/counseling (Prevention Case Management, Partner Counseling and Referral Services, Health Department/Community Based Organization programs for prevention interventions with PLWH) if consumers need additional assistance in decreasing risk behavior.

Volunteers: The Mpowerment Project uses volunteers to conduct the intervention; therefore the agency should know and disclose how their liability insurance and worker's compensation applies to those volunteers.

QUALITY ASSURANCE

Quality assurance activities for both coordinators and participants should be in place when implementing the Mpowerment Project:

Coordinator: Training for coordinators should address the following three areas: (1) completion of a training workshop, including review of the intervention theory and materials; (2) participation in practice sessions; and (3) observed co-facilitation of groups, including practice of mock Core Groups and M-groups. It is preferred, though not required, that Supervisors of Coordinators also attend a training workshop, which includes a review of the intervention theory and materials. Agencies should have in place a mechanism to assure that all session protocols are followed as written. QA activities can include direct or videotaped observation and review of sessions by key staff involved with the activity. This review should focus on adherence to session content, use of appropriate videotapes with adequate facilitation of discussions; accessibility and responsiveness to expressed participant needs; and important process elements (e.g., time allocation, clarity). Selected intervention record reviews should focus on assuring that consent forms (signed either by the participant if he/she is over 18 or emancipated, or by a legal guardian) are included for all participants when required, and session notes are of sufficient detail to assure that clients are participating actively.

Participants: Participants' satisfaction with the intervention and their comfort should be assessed after each M-group. Process monitoring systems should also track the number of sessions each participant attends, as well as reasons for non-attendance. Process monitoring should also track the frequency of M-groups, Core Groups and outreach events, the numbers and diversity of individuals attending each activity, and track the process of developing outreach events.

MONITORING AND EVALUATION

Evaluation and monitoring intervention activities include the following:

- Collect and report standardized process and outcome monitoring data consistent with CDC requirements;
- Enter and transmit data for CDC-funded services on PEMS (Program Evaluation Monitoring System), a CDC-provided browser-based system, or describe plans to make a local system compatible with CDC's requirements;
- Collect and report data consistent with the CDC requirements to ensure data quality and security and client confidentiality;
- Collaborate with CDC in assessing the impact of HIV prevention activities by participating in special projects upon request.

Project may also want to evaluate and monitor intervention activities using process evaluation methods developed specifically for the intervention:

- These include process evaluation methods designed specifically for M-groups, Formal outreach, Core Group, and publicity;
- These process evaluation forms are designed to be used by the Coordinators and Core Group for reflecting upon success of the project and for redesigning groups and publicity over time

KEY ARTICLES AND RESOURCES

[1]Kegeles SM, Hays RB, Coates T.J. (1996). The Mpowerment Project: A community-level HIV prevention intervention for young gay men. American Journal of Public Health, 86(8), 1129-1136.

[2]Kegeles SM, Hays RB, Pollack LM, Coates T.J. (1999). Mobilizing young gay/bisexual men for HIV prevention: A two-community study, AIDS, 13(13), 1753-1762.

Resources

Hays, RB, Kegeles, SM, Rebchook, GM. The Mpowerment Project: community-building with young gay and bisexual men to prevent HIV. American Journal of Community Psychology, 2003; 31, 301-312.

PROCEDURAL GUIDANCE FOR IMPLEMENTATION OF THE REAL AIDS PREVENTION PROJECT (RAPP)

CBO PROGRAM ANNOUNCEMENT RFP 04064
DEPARTMENT OF HEALTH AND HUMAN SERVICES

DESCRIPTION OF RAPP

The Real AIDS Prevention Project (RAPP) is a community-level HIV prevention intervention designed to help low-income women (aged 15-34) and their partners reduce their risk for HIV infection. The intervention objectives are to increase consistent condom use by women and their partners, to change community norms so that practicing safer sex is seen as the acceptable norm, and to involve as many people in the community as possible. The program has two phases: 1) community assessment, which involves finding out about the community and how to talk to women and their partners about their risk for HIV infection, and 2) recruitment, which involves the community in a combination of risk reduction activities directed toward these women and their partners. This intervention has been packaged by CDC's Diffusion of Effective Behavioral Interventions (DEBI) project and information on obtaining the intervention training and materials is available at www.effectiveinterventions.org.

RAPP has been demonstrated to be effective in helping women change their behavior. The intervention is based on the Transtheoretical Model of Behavior Change, popularly known as "Stages of Change."[1,2] This theory says that people do not change behavior all at once, but go through a series of stages. Women in the study were helped to move toward consistent condom use by being given condoms and messages tailored to their stage of change. Two other theories guided the RAPP activities. The Motivational Theory says that people are more likely to adopt new behaviors when influential members of the community have already adopted them,[3] and the Social Cognitive Theory says that people learn new behaviors best when trusted sources, such as their peers practice the behavior and when people have the opportunity to increase both knowledge and skills related to the behavior.[4]

Research has indicated that, after participating in the RAPP intervention, women living in high-risk intervention communities were more likely than the women in the comparison communities to have initiated condom use with their steady partners and negotiated condom use with steady and casual partners. Women at very high risk (sex workers) were more likely to use condoms consistently with both steady and casual partners.[5-9]

CORE ELEMENTS, KEY CHARACTERISTICS, AND PROCEDURES

Core Elements are those components that are critical features of an intervention's or strategy's intent and design and that are thought to be responsible for its effectiveness. Consequently, they must be maintained without alteration to ensure program effectiveness. Core elements are derived from the behavioral theory upon which the intervention or strategy is based. They are essential to the implementation of the program and cannot be ignored, added to, or changed. There are 5 core elements of RAPP:

1) Recruit people from the community to become part of the peer network and volunteer several hours each week to talk to women and men about HIV prevention and related issues.

2) Conduct encounters that are one-on-one conversations led by trained peer volunteers who ask questions about attitudes and condom use to find out the person's stage of change. Then, based on the response, the peer volunteers give women a message aimed at encouraging them to begin or continue condom use.

3) Disseminate role model stories that are based on interviews with people about their decision to change their behavior.

4) Recruit local businesses, organizations and agencies to become part of the community network to support the project's goals such as displaying and/or distributing role model stories and other educational materials and sponsoring activities.

5) Conduct small-group activities to promote safer sex and host HIV/AIDS presentations. Recruitment for participation in the small group activities is central to the outreach activities of RAPP.

Key Characteristics are crucial activities and delivery methods for conducting an intervention, which may be tailored for different agencies and at-risk populations to meet the needs of the target population and ensure cultural appropriateness of the strategy. RAPP has the following key characteristics:

- Hire an outreach specialist who is a recognized leader in the project community. The outreach specialist coordinates the project activities, conducts outreach, and manages the peer network and community network.
- Conduct a community assessment to identify the best ways and places to reach community members and to build interest in the project.
- Recruit community members and interview them about the experiences that made them think about, decide to start, start, or continue to change their behavior.
- Write short role model stories, based on the interviews, about people in different situations and stages of change regarding condom use.

- Train peer volunteers to have one-on-one conversations with members of the target population during which the volunteer asks questions about attitudes and condom use to find out the person's stage of readiness to change.
- Have peer volunteers distribute condoms, role model stories, and other educational materials during the stage-based discussion.
- Conduct presentations for larger groups, such as members of organizations, employees at businesses, and staff or clients of local agencies, to educate community members about HIV and ways to prevent infection.
- Debrief peer volunteers regularly to identify and address problems, support each other, and assess progress.
- Provide short booster trainings for peer volunteers to review information and develop new skills. Trainings can be on topics other than HIV and condoms.

Procedures describe the activities that make up the content of the intervention and provide direction to agencies or organizations regarding the implementation of the intervention.

The first phase of the project is **Pre-Implementation** or **Getting Started**. This phase involves the preparations that are made to begin the project activities and usually takes two to four months. These activities include conducting a community needs assessment, arranging for materials to hand out, and recruit and train peer volunteers. The first step of the community assessment is to identify key community members and soliciting community involvement. A promotional video can be used when describing the project with community groups since it was designed to give an overview of the project and to get people excited about RAPP.

The second step of the community assessment is knowing your community. Knowing the community involves not only identifying physical boundaries and collecting information about who lives in it, but also finding out what members think about HIV prevention, what they see as the issues related to HIV, what the barriers are to changing their beliefs and attitudes, and what their ideas are about overcoming these barriers.

Agencies implementing RAPP should conduct **Focus Groups** and **Key Participant Interviews** to gather information about what people want to know about HIV prevention, what messages they want to hear and how they want to hear them. Focus groups are discussion groups that include people who are invited because of their knowledge about a specific topic.[10-11] Include people who know a lot about the community and can provide information about community attitudes and perceptions. Their insights can help agencies plan ways to adapt RAPP so it meets the needs of the community in a way that is acceptable to the people who live there. In addition, focus groups can point out some obstacles agencies may face in implementing RAPP as well as strategies to overcome them.

Agencies should conduct at least four focus groups, with eight to ten people from the community. To get the widest range of opinions, the focus groups should be conducted with the following people: community leaders and other influential people who can "make or break" the project, adult females who can share issues specific to women, adult males who can provide insights from the male perspective, and teenagers. A key component to having successful focus

groups is having a trained group facilitator lead and direct the group discussions. Agencies should provide or seek training for inexperienced staff that will conduct the focus groups.

Key participant interviews are one-on-one interviews conducted with people who know about the community and about the people who will be affected by the project's activities. In the interviews, participants should be asked about attitudes, beliefs and perceptions related to HIV prevention. Recognized community leaders, residents of the community, and people with alternative lifestyles such as sex workers should be interviewed. Key participant interviews can be done during the same time period as the focus groups. Agencies should plan to complete both in six to eight weeks.

The second phase of RAPP is **Implementation or Running the Project**. This phase includes implementing outreach activities that make up the project, tracking them, getting feedback from volunteers, and making adjustments. Agencies should begin distribution of role model stories by peer network volunteers as well as recruitment of the community network in the third or fourth month of the project. In the fourth or fifth month, agencies should begin to conduct stage-based encounters, develop new role model stories, and recruit hosts for safer sex programs and sponsors for HIV presentations.

Outreach is a major part of RAPP. It can take on several forms, as described below.

The Peer Network: The Peer Network is one of the 5 core elements of RAPP. It is a group of six to eight community members who volunteer two or three times a week to go out in the community, talk to people about safer sex and hand out role model stories, educational materials, and condoms. A paid outreach specialist manages their activities. To create a peer network, agencies will need to recruit members of the community, orient them to the project and give them training for street outreach, stage-based encounters and other activities they will do in the community.

Active recruiting and training for the peer network should be conducted at least twice a year because dropouts may occur. Agencies should employ the following strategies for maintaining their peer network: identify responsibilities early, provide incentives such as gift certificates, provide a special bag for volunteers to carry their materials in, certificates for completed trainings, and ongoing support.

Stage-Based Encounters: A stage-based encounter is a specific kind of outreach activity that is based on the Stages of Change Theory. It is one-on-one, face-to-face, mini-interview aimed at helping women think about changing a risky behavior, such as having unprotected sex, or maintaining a healthy behavior, like using condoms all the time.

In a stage-based encounter a trained interviewer (a peer volunteer or outreach specialist) asks a few questions to determine readiness for behavior change. Then the interviewer responds in a way that will help the person change a behavior or continue doing the new behavior. This process is called staging. Stage-based outreach involves five things: (1) Making contacts where people in the community live, work, and play; (2) asking a few simple questions to find out if people are using condoms; (3) determining the person's stage; (4) responding in a way that gives

information, encouragement and/or positive feedback specific to the person's stage of behavior change; and (5) handing out role model stories and condoms.

Peer volunteers and the outreach specialist should carry role model stories and condoms every time they go out to do street outreach. Sometime during the stage-based encounter they should offer the person to whom they are talking a story, a condom, and information on where to get counseling and testing for HIV or help with other problems. This type of encounter should take about five to ten minutes.

Agencies implementing RAPP should conduct a two-day training to introduce stage-based encounters for everyone in the peer network. This training should cover the stages of change, influencing factors, strategies for staging, and instructions for reporting the activity.

Role Model Stories: The dissemination of role model stories within a community is a very important part of RAPP outreach. Role model stories are printed stories based on interviews with people about their decision to change their behavior. RAPP role models are people who have decided to practice safer sex and who share their story about why they changed their behavior. In these stories, people in different situations and stages of change tell about real-life experiences that made them think about, start, or continue using condoms. Because role model stories are based on the experiences of community members, they deal with issues to which other residents can relate. This makes role model stories culturally sensitive and culturally appropriate.

Role model stories are framed using the Stages of Change Theory. Each story relates to changing one behavior, is written for one of the five stages of change, and uses one or more of the influencing factors. The purpose of the stories is to help people move toward consistent condom use. Agencies should develop stories that show how people move from not using condoms or using them only sometimes to using them all the time.

The role model stories should be developed into a colorful pamphlet or flyer that should fit in a pocket or purse. In addition, agencies developing their own role model stories or adapting existing ones should create an annual story plan. This plan outlines the number of stories an agency should put out every month, the stages and topic that will be dealt with and when each story will be distributed. Ideally, agencies should develop two new stories each month (a total of 24 stories a year).

If resources are limited, agencies should use existing stories that are available in the intervention package. Agencies can use them in their original form or adapt them so that they fit the community better.

Community Network: The community network is a group comprised of businesses, agencies and organization in the agencies' community. The primary function of the community network, another core element of RAPP, is to provide a place where role model stories are easily and widely available for their clients and customers. By making stories available to a large number of people, the community network provides an opportunity for community members to get HIV prevention messages.

The more businesses, agencies and organizations that are involved, the more agencies increase awareness of HIV and AIDS in the community. Agencies should have at least 25 members as part of the community network. Examples of businesses to recruit include nail and hair salons, barbershops, welfare offices, restaurants, banks, drug stores, newsstands, convenience stores, record stores, clothing shops, healthcare agencies, and schools.

Invitations for businesses and agencies to be involved in RAPP should be done in person, face-to-face, and should include a brief description of the project, community network member expectations, and a determination of the members' level of support for the project. Members of the community network should be sent at least two letters each year to say thanks for their support of RAPP and to report on the project's activities and accomplishments to keep them involved. Information about community networking activities should be recorded on the RAPP Activity Form.

Small-Group Activities: The small-group activities are another core element of RAPP and give people an opportunity to learn about HIV prevention. The outreach specialist and the peer volunteers should organize two kinds of small group activities: safer sex programs and HIV informational presentations.

Safer sex presentations are usually hosted by people in their homes, but can also take place in other settings, such as community centers, wherever people feel comfortable. The agency outreach specialist or peer volunteers should recruit residents from the community to host the party and invite six or eight of their friends over to play educational games, win prizes and learn about HIV prevention. The outreach specialist directs the activities. Peer volunteers may also host, help with, and lead safer sex presentations, which should last about one and a half hours. The host should be given an incentive in private such as a gift certificate. Information about the party should be recorded on the RAPP Activity Form.

HIV presentations provide a more formal group setting where people can learn about how HIV is spread and prevention strategies. The agency outreach specialist should conduct these presentations for the staff of local agencies, businesses and organizations that are apart of the community network as well as non-members. The presentations should last about one hour, with an optional follow-up session.

RESOURCE REQUIREMENTS

RAPP has 5 core elements that, when used together, can help people change their behavior. Once the project is fully up and running, the outreach activities connected with each of these elements should be going on at the same time. To be sure that this happens, these activities need to be coordinated in the field by one or more persons who also has outreach responsibilities. This person is the paid outreach specialist, whose role is vital to the success of the project. Agencies should hire or bring the outreach specialist onto the project as soon as possible after deciding to implement RAPP. The outreach specialist has major responsibilities during both the pre-implementation and implementation phases of the project. During the pre-implementation phase, the outreach specialist is responsible for conducting the community needs assessment that includes recruiting people for the focus groups and key participant interviews and identifying

volunteers for the peer network and the community network. After the community assessment phase is complete, the outreach specialist is responsible for the following: (1) conducting outreach, (2) scheduling peer network activity; (3) overseeing and tracking peer network activity; (5) training volunteers; (6) writing new role model stories; (7) conducting community networking; (8) facilitating safer sex parties; and (9) monitoring and record keeping. Agencies should consider the size of the community to be served, epidemiological data on HIV incidence rates and AIDS cases, and services available in their community when determining the number of outreach specialists needed for RAPP.

RECRUITMENT

Peer Volunteers: Conducting community outreach and small group activities using peer volunteers is a major function of the RAPP intervention. RAPP takes advantage of the power of peers to influence others by using them to encourage people to adopt new ideas about condom use and safer sex. Key characteristics of peer volunteers are that they like to talk to people on the street and are comfortable discussing HIV and other sensitive topics. The peer network should include persons of different ages, gender, and race based on the community that is being served. Members of the community can be recruited to join the peer network in the following ways:

- Active recruitment by the outreach specialist
- Volunteers of the network can invite their friends to join
- Post flyers and send out formal invitations
- Referrals from community based organizations, healthcare providers, homeless shelters, religious institutions, schools and other agencies

Role Models: RAPP role model stories are based on the real life experiences of people in the community and are written in the words of the people who tell them. Key characteristics of role models are that they use condoms consistently, or are in the process of making changes toward using condoms consistently, can describe experiences they have had trying to use condoms, and can explain how and why they have changed their behavior. Ways to recruit role model stories include:

- Solicit stories from peer volunteers
- Advertise on the back of the role model stories handed out by peer volunteers
- Post flyers in the community
- Recruit people who come to safer sex parties to tell their stories
- Referrals from community based organizations, healthcare providers, homeless shelters, religious institutions, schools and other agencies

Local Community Businesses: Obtaining program support from community organizations and businesses is also an important function of RAPP. Peer volunteers and the outreach specialist can recruit community network members from businesses and agencies that they use and places where their friends and family visit. Invitations to be involved should be conducted in person.

Incentives can be used to effectively enhance retention of volunteers in the peer network, recruitment of role models and participation in the community network. For example, gift certificates, monetary incentives, and food can be used as token of appreciation.

PHYSICAL SETTING CHARACTERISTICS

The intervention needs a place to hold trainings and staff meetings. Ideally the place should have comfortable seating for having discussions. Staff meetings can be held in the CBO's office space. Agencies implementing RAPP should choose a training location that is easily accessible from public transportation routes. The recruitment and risk reduction conversations take place in community venues where the target population lives, works, and socializes.

NECESSARY POLICIES AND STANDARDS

Before an agency attempts to implement RAPP the following policies and procedures should be in place to protect clients, the agency, and staff:

Targeting of Services: Agencies must establish criteria for, and justify the selection of, the target populations. Selection of target populations must be based on epidemiological data, behavioral and clinical surveillance, and the state or local HIV prevention plan created with input from the state or local community planning group(s).

Safety: Agency policies must exist for maintaining safety of workers and clients. Plans for dealing with medical or psychological emergencies must be documented.

Confidentiality: A system must be in place to ensure that confidentiality is maintained for all participants in the program. Before sharing any information with another agency to which a client is referred, signed informed consent from a client or his/her legal guardian must be obtained.

Linkage of Services: Recruitment and health education and risk reduction must be linked to counseling, testing, and referral services for clients of unknown status, and to care and prevention services for people living with HIV (PLWH). Agencies must develop ways to assess whether and how frequently the referrals made by staff were completed.

Data Security: Collect and report data consistent with CDC requirements to ensure data security and client confidentiality.

Cultural Competence: Agencies must strive to offer culturally competent service by being aware of the demographic, cultural, and epidemiological profile of their communities. Agencies should hire, promote, and train staff across all disciplines to be representative of and sensitive to these cultures. In addition, materials and services must be offered in the preferred language of clients/consumers where possible, or translation should be available if appropriate. Agencies should facilitate community and client/consumer involvement in designing and implementing prevention services to ensure that important cultural issues are incorporated. The Office of

Minority Health of the Department of Health and Human Services has published the *National Standards for Culturally and Linguistically Appropriate Services in Health Care* which should be used as a guide for ensuring cultural competency in programs and services. Please see the Cultural Competence section in the introduction of this document (page 9) for standards for developing culturally and linguistically competent programs and services.

Personnel Policies: Agencies conducting recruitment, outreach, and health education and risk reduction, must established a code of conduct. This code should include, but not be limited to, no drug or alcohol use, appropriate behavior with clients, and no loaning or borrowing of money.

Volunteers: If the agency is using volunteers to assist in or conduct this intervention, then the agency should know and disclose how their liability insurance and worker's compensation applies to volunteers. Agencies must ensure that volunteers also receive the same training and are held to the same performance standards as employees. Agencies must also ensure that volunteers sign and adhere to a confidentiality statement. All training should be documented.

QUALITY ASSURANCE

For RAPP to work, all five core elements must be implemented together. Quality assurance activities allows agencies to track and document how RAPP was implemented and allow for changes to be made when necessary to meet RAPP outcomes. Quality assurance activities for both agency staff and volunteers should be in place when implementing RAPP.

RAPP Outreach Specialists: RAPP outreach specialists should have extensive knowledge of HIV transmission and statistics in their local jurisdictions as well as national statistics. Outreach specialists should reflect the target population in race, gender and age and will be expected to deliver the information in a non-threatening and culturally relevant manner.

RAPP Training: Peer Network Training - During the beginning of the RAPP intervention, the outreach specialist and peer volunteers should be trained by a professional who is strongly familiar with the curriculum. Later training sessions can be conducted by the outreach specialist using the materials in the RAPP Training Manual. Volunteers should have this training, followed by experience in doing peer networking before they participate in the stage-based encounter training.

Role Model Stories Training: This training should first be conducted by a trainer who is familiar with the application of stages of change theory and who has experience in conducting interviews. Subsequent training sessions can be conducted by the outreach specialist or agency staff. Additional one-on-one training may be needed.

Staged-Based Encounters Training (Two Days): This training should be conducted by the outreach specialist or agency staff. Participants of this training should have attended the one-day training for the peer network. The first day of this training should focus on identifying stages of change and the second day should concentrate on identifying and using influencing factors.

The two sessions should not be held more than one week apart. The training should be conducted with small groups of six to eight trainees. Frequent review and periodic re-training sessions with peer volunteers may be necessary.

For all RAPP Training: Quality assurance activities can include direct observation and review of training conducted by the outreach specialist. The review could focus on the quality (or adherence to the fidelity) of the training delivered, and responsiveness and openness of the volunteers to the outreach facilitator. The outreach specialist should collect all evaluation forms following the training and ensure confidentiality of the peer volunteers. In addition, outreach specialists should ensure that all participants are actively participating in the training activities. Monthly meetings with supervisors to discuss progress and/or opportunities for change are encouraged.

RAPP Outreach Activities: All RAPP outreach activities should be recorded on the RAPP Activity Reporting Form provided in the RAPP implementation package. The RAPP Activity Form allows agencies to track RAPP activities (core elements) that are implemented to ensure the intervention is being implemented as intended by the original researchers: The forms monitor the following:

- Who has been contacted, when, where and the outcome.
- The number and types of activities being conducted
- The type of persons being reached (by gender, age, risks)
- The number and type of referrals being made
- The supply of role model stories at drop sites.
- The number of safer sex parties and HIV presentations conducted

Keeping these records will help agencies monitor and assess how each RAPP core element is being implemented in the community.

MONITORING AND EVALUATION

Evaluation and monitoring intervention activities include the following:

- Collect and report standardized process and outcome monitoring data consistent with CDC requirements;
- Enter and transmit data for CDC-funded services on PEMS (Program Evaluation Monitoring System), a CDC-provided browser-based system, or describe plans to make a local system compatible with CDC's requirements;
- Collect and report data consistent with the CDC requirements to ensure data quality and security and client confidentiality;
- Collaborate with CDC in assessing the impact of HIV prevention activities by participating in special projects upon request.
- Collect and report data on the following indicators:
    - **I.A-** The mean number of outreach contacts required to get one person with unknown or negative serostatus to access counseling and testing.

- **I.B-** The proportion of person who access counseling and testing from each of the following interventions: individual level interventions and group level interventions.
- **IV.A-** Proportion of client records with the CDC-required demographic and behavioral risk information.
- **V.A -** The mean number of outreach contacts required to get a person (living with HIV, their sex partners and injection drug-using contacts or at very high risk for HIV infection) to access referrals made under this program announcement.

KEY ARTICLES AND RESOURCES

[1]Prochaska JO, DiClemente CC. (1983). Stages and processes of self-change of smoking: toward an integrative model of change. Journal of Consulting Clinical Psychology, 51, 390-395.

[2]Prochaska J, DiClemente CC. (1985). Common processes of self-change in smoking, weight control and psychological distress. IN S. Shiffman and TA Willis, eds. Coping and Substance Abuse. New York: Academic Press.

[3]Rogers EM. (1995). Diffusion of Innovations (4th ed.). New York: Free Press.

[4]Bandura A. (1977). Social Learning Theory. Englewood, N.J: Prentice-Hall.

[5]Adams J, Weissfeld L, Lauby J, Stark M. (1998). Effects on teenage women of a community-level HIV prevention intervention. Paper presented at 126 Annual Meeting of American Public Health Association, Washington, D.C.

[6]Person B, Cotton D. (1998). A model of community mobilization for the prevention of HIV in women and infants. Public Health Reports, 3 (suppl. 1), 89-98.

[7]Smith P, Person B, Adam J. (1998). Women who trade sex: results from a community intervention trial. Presented at the International Conference on AIDS, 1998.

[8]Terry M, Liebman J, Person B, Bond L, Dillard-Smith C, Tunstall C. (199**?**). The women and infants demonstration project: an integrated approach to AIDS prevention and research. AIDS Education and Prevention, 11(2):107-21.

[9]Lauby JL, Smith PJ, Stark M, Person B, Adams J. (2000) A community-level prevention intervention for inner city women: Results of the Women and Infants Demonstration Projects. American Journal of Public Health 90(2), 216-222.

Krueger RA. (1988). Focus groups: A practical guide for applied research. Sage Publications: Newbury Park, CA.

Morgan DL, Krueger RA. (1998). The focus group kit. Sage Publications: Thousand Oaks, CA.

For more information on receiving technical assistance or training on this intervention, please visit www.effectiveinterventions.org.